DELTA DENTAL®

Enrollment and Change Form

STEP #1

Check below to indicate plan enrollment

☐ I Elect enrollment in the dental program

☐ I Decline dental coverage

STEP #2

Check appropriate options

☐ New Enrollment Hire Date: _____   ☐ Address Change

☐ Terminate Dependent **or** Add Dependent Date: _____ _____

☐ Name Change:
From _____TO:_____

☐ Open Enrollment
Indicate action you are making for open enrollment
_____

☐ Qualifying Event
☐ Marriage   ☐ Divorce   ☐ Birth   ☐ Other_____

Enrollment due to a qualifying event requires proof validating the event

STEP #3

Complete Employee Information

☐ Board of Education Employee
☐ County Government Employee

Indicate the Department or School Location where you work: _____

Work Phone: _____   Home *or* Cell Phone: _____   Male or Female

Employee Name: _____ SS #: _____ Date of Birth: _____

Address: _____City: _____ State: ____ Zip: _____

STEP #4

Please list all family members to be enrolled or terminated

First, M.I., & Last Name (please circle child or step-child)		Social Security #	Birth Date	Sex
	SP	- -	- -	M F
	CH SCH	- -	- -	M F
	CH SCH	- -	- -	M F
	CH SCH	- -	- -	M F

Enrollment of a child over the age of 19, verification of eligibility must accompany this enrollment form.
Step-Children **MUST** reside in your household & natural parent must remain married to you and also reside in your household.

STEP #5

By signing below, I agree to all terms and conditions of enrolling in and continued enrollment in the Williamson County Dental program, as such exist on the date of my enrollment as reflected below, and as such may change from time to time, with or without notice to me. I further represent and warrant that all information given by me is accurate, current, and complete to the best of my knowledge. I agree to allow the Williamson County Benefits Department to have the appropriate deductions taken from my paycheck according to my above enrollment options.

Employee's Signature: _____ Date: _____